



# **AFFIDAVIT OF IDENTITY - For Disabled Individual in Facility**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

MEDICAL SERVICES DIVISION

SFN 690 (8-2007)

Individual's Full Name		Date of Birth
Place of Birth (City)	State	Country

My Full Name (please print)
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**Under penalty of perjury, I certify that I know the identity of the individual listed above and that the information I have provided above is true and correct to the best of my knowledge. I understand that state and federal laws provide for fine, imprisonment, or both for any person convicted of providing false information to obtain Medicaid benefits to which he or she is not entitled.**

Signature		Date
Title (Director, Administrator)	Name of Facility	

Return ORIGINAL to:

Social Services Name			
Address	City	State	Zip Code